Certification Board for Alcohol and Drug Professionals (CBADP)
3101 West 41st Street, Suite 205, Sioux Falls, SD 57105
Phone: 605-332-2645 Fax: 605-332-6778
Email: cbadp@midconetwork.com Web: www.dhs.sd.gov/brd/CBADP

APPLICATION FOR CERTIFICATION UPGRADE

Attached please find the Application for Certification Upgrade. Please complete the application in its entirety. Do not leave information blank or attach separate sheets indicating 'see attached', even if you have previously documented the information.

Applications for upgrade can be submitted at any time. All requirements must be completed at the time of application for certification. Extensions will not be granted to complete courses or work experience requirements. Applications will be denied if there are any incomplete items in the application portfolio.

Your supervisor(s) must complete the 'Chemical Dependency Counselor Evaluation by Supervisor' form and send it directly to the Certification Board for Alcohol and Drug Professionals (CBADP). Also, please mail or give the 'Professional Recommendation' form to three professional colleagues and have them send it directly to the CBADP. If you have completed work experience at more than one agency, please make a copy of the 'Work Experience Verification' form and send it to each agency for verification of all work experience hours.

Applicants applying for upgrade from Level I to level II or from level II to Level III must have successfully passed the national written examination. Documentation of such must be on file with the Certification Board for Alcohol and Drug Professionals and/or documentation provided with the application.

The CBADP is required to comply with SDCL 25-7A-56 which is a prohibition against the issuance of professional license, registration, certification, or permit of application in the event of child support arrearage. Applicants listed on the State Registry will not be granted Trainee Recognition, Certification, or Recertification until arrangements have been made with the Department of Social Services, Office of Child Support Enforcement and the individual's name is cleared via monthly written reports from that office.

If you have any questions concerning this application or need assistance, please contact the CBADP Administrative Office.

SEND COMPLETED APPLICATION, TRANSCRIPT(S), AND FEE TO:

CBADP
3101 West 41st Street, Suite 205
Sioux Falls, SD 57105

Application for Certification Upgrade

A $150.00 check or money order must accompany this application.
Submit to: CBADP, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105

I AM APPLYING FOR: ___ CCDC Level II ___ CCDC Level III

CERTIFICATION TRACK: ___ Academic Track ___ Experience Track

PERSONAL DATA:

Name: _____
First Middle Last Maiden

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____Work Fax: _____

Email: _____

Social Security #: _____ Birth date: _____

CURRENT EMPLOYMENT:

YOU ARE REQURED TO SUBMIT A COPY OF YOUR CURRENT JOB DESCRIPTION

Agency Name: _____

Agency Mailing Address: _____

City: _____ State: _____ Zip: _____

Job Title: _____

Name of CCDC Supervisor: _____

Educational/Academic Data

Official transcripts must be submitted for all education. If you have a college degree, you do not have to send your high school transcript.

High School Attended: _____

Date of Graduation: _____

GED: _____ Date: _____

Where Issued: _____

COLLEGE/UNIVERSITY:

Name	Location	Enrolled From	Enrolled To	Degree(s) Earned

SPECIALIZED EDUCATION DOCUMENTATION:

List all completed specialized educational courses. All courses must equal 3 or more semester credits and earn a "C" grade or higher.

Requirement	Name of College or University	Prefix - Course Number	Name of Course	Credit Hours	Term Taken	Grade
Example	FSU	HS 212	Study of Alcohol	3	Fall '95	B
Intro to Alcohol Use and Abuse						
Intro to Drug Use and Abuse						
Foundations of Individual Counseling						
Alcohol & Drug Group Counseling						
Alcohol & Drug Treatment Continuum						
Professional Ethics for the CD Counselor						
Counseling Families with Alcohol or Other Drug Issues						
Cultural Competency **OR**						
Special Populations						
CD-Specific Elective						

Work Experience Documentation

All experience must be specific to chemical dependency counseling. List all relevant experience, beginning with your current place of employment. Verification must be received for all experience.

Applicant's Name: ____

Agency Name: ____

Address: ____

City: ______________________________ State: ________ Zip: ____________________

Phone: ______________________________ Supervisor: ____________________________

Job Title: ____

Dates of Employment: From ______________________________ To ______________________________

Was the experience Full Time: ______________ Part Time: ______________ Volunteer: ______________

Agency Name: ____

Address: ____

City: ______________________________ State: _______ Zip: ____________________

Phone: ______________________________ Supervisor: ____________________________

Job Title: ____

Dates of Employment: From ______________________________ To ______________________________

Was the experience Full Time: ______________ Part Time: ______________ Volunteer: ______________

Agency Name: ____

Address: ____

City: ______________________________ State: ______ Zip: ____________________

Phone: ______________________________ Supervisor: ____________________________

Job Title: ____

Dates of Employment: From ______________________________ To ______________________________

Was the experience Full Time: ______________ Part Time: ______________ Volunteer: ___________

(Duplicate page, if necessary)

Work Experience Verification

<u>Applicant</u>: All experience must be verified. Make a copy of this form for each agency where you completed work experience. Complete the top section and send the form to all agencies, employers, internship sites, etc. for verification of all work experience hours.

Applicant's Name: _____

Address: _____

City: _____State: _____ Zip: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

APPLICANT STOP HERE

THE FOLLOWING MUST BE COMPLETED BY THE AGENCY, EMPLOYER, INTERNSHIP SITE, ETC.

The applicant listed above is applying for certification as a chemical dependency counselor. Please verify the work experience for this individual and return this form directly to the Certification Board for Alcohol and Drug Professionals, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105. If the above information is not correct, please make corrections, initial and mail with a copy of the person's written job description.

I hereby attest that the above information is true and correct. This person was involved in the supervised counseling of diagnosed alcohol and drug abuse clients with the majority of their time spent in individual, group and/or family counseling; and, the remaining experience was related to the AODA Counselor Core Functions.

☐ I verify that the required hours of ongoing supervision have been met (i.e. for every ten hours of client contact, there has been a minimum of one hour of supervision between the clinical supervisor and the applicant).

Signature: _____

Name: _____

Name of Agency: _____

Address: _____

City: _____State: _____Zip:_____

Phone: _____ Title: _____

Date: _____

Total **<u>number of hours</u>** of qualifying work experience: _____

Professional Code of Ethics

The Professional Code of Ethics applies equally to all Certified Chemical Dependency Counselors, Certified Prevention Specialists, Trainees, Interns, and individuals in the process of applying for certification. The Certification Board for Alcohol and Drug Professionals (CBADP) believes that all people have rights and responsibilities through every stage of human development. The goal of the CBADP is for addiction professionals to treat everyone with the dignity, honor, and reverence that is fitting to them.

The Professional Code of Ethical Conduct entitles human beings to the physical, social, psychological, spiritual, and emotional care necessary to meet their individual needs. All Certified Professionals, Trainees, and Interns have a responsibility to adhere to the following guiding principles:

1. That I have a total commitment to provide the highest quality of care for those people who seek my professional services.
2. That I will dedicate myself to the best interests of clients and assist them to help themselves.
3. That at all time, I shall maintain a professional relationship with clients.
4. That I will be willing, when I recognize that it is in the best interest of the client, to release or refer them to another program or professional.
5. That I shall adhere to the laws of confidentiality and professional responsibility of all records, materials, and knowledge concerning clients.
6. That I shall not in any way discriminate against clients or other professionals.
7. That I shall respect the rights and views of other professionals and clients.
8. That I shall maintain respect for institutional policies and management functions within agencies and institutions, but I will take the initiative toward improving such policies if it will best serve the interest of clients.
9. That I have a commitment to assess my own personal strengths, limitations, biases, and effectiveness on a continuing basis; that I shall continuously strive for self-improvement and professional growth through further education and/or training.
10. That I have a responsibility for appropriate behavior in all areas of my professional and private life, and to provide a positive role model especially in regard to the personal use of alcohol and other drugs.
11. That I have a responsibility to myself, my clients, and other associates to maintain my physical and mental health.
12. That I respect the client's right to worship or not, according to their conscience and beliefs, and that I will not impose my own beliefs, values, or standards upon them.
13. That I have a professional responsibility to understand and appreciate different cultures for persons whom are or may be in my care or are recipients of my professional services. I will demonstrate sensitivity to cultural differences in my professional practices.
14. That I have a regard for an individual's needs and rights to equal protection and due process under the laws of the State of South Dakota.

Private conduct is a personal matter, except when such conduct compromises the fulfillment of professional responsibilities or may endanger the health or safety of clients who are or may be under my care. As a professional, I have a responsibility to report, whether obvious or perceived, any ethical violations or concerns related to my peers.

I understand and subscribe to the preceding professional code of ethics and understand that any violation of the principles will be grounds for disciplinary action and sanctions.

☐ **By checking this box, I hereby attest that I have read and will comply with the 2004 Codes of Ethics and Standards of Practice of the Certification Board for Alcohol and Drug Professionals.**

The Codes of Ethics can be viewed and/or printed at: www.dhs.sd.gov/brd/CBADP. Applicants who have not read the Codes of Ethics and have not checked the box above will not be granted this certification upgrade by the CBADP.

_____ _____

Signature of Professional Date

Authorizations and Releases

I hereby attest that I have not been convicted of, plead guilty, or no contest, to any felony, or to any crime involving moral turpitude, or like offense within the past five years.

I hereby understand that being convicted of, or pleading guilty, or no contest, before a court in this state or any other state, or before any federal court for any offense punishable as a felony, or like sanction, will be grounds for denial of, or revocation of certification, recertification, or trainee recognition.

I hereby understand that if I have had a felony conviction, and/or pled guilty, or no contest, or received a suspended imposition of sentence, it must have been at least five (5) years prior to the date of application for trainee recognition, student internship status, certification or recertification. I also understand that all sentencing requirements must be completed or satisfied prior to the date of application for any of the above.

I confirm that I have not been denied certification or licensure or had any disciplinary sanctions against me from this or any other certifying or licensing authority in this or any other state. If I have been denied or had disciplinary action, I have notified the Certification Board for Alcohol and Drug Professionals (CBADP) in writing of this action.

I hereby authorize the CBADP to release to any agency, facility, organization, or individual any and all information necessary for verification of credentials.

I hereby authorize any agency, facility, organization, or individual to release any and all information necessary to fully and properly evaluate my application before the CBADP. The CBADP reserves the right to request further information or documentation to evaluate the application and/or professional competence of individuals.

I hereby release and hold harmless the CBADP, its Board of Directors, its officers, its employees, and any agency, facility, organization, or individual from any and all manner of suits, actions, claims, and judgments which might arise from such efforts to further substantiate and document my application.

I hereby understand that the CBADP can deny or revoke certification, trainee recognition, or student internship status on the basis of misrepresentation on my application, or any other application, to include intentionally false or misleading statements or intentional omissions. I understand that I will be barred from applying for certification or recertification for not less than two (2) years if it is proven that I have misrepresented the facts on any aspect of my application, or any other application, for trainee recognition, student internship status, certification or recertification.

I hereby certify that the information contained herein is correct and true, and that I understand the application and these authorizations and releases.

On the line below, please print your name the way you would like it to appear on your certificate:

_____

_____ _____

Signature of Professional Date

CHEMICAL DEPENDENCY COUNSELOR EVALUATION BY SUPERVISOR

INSTRUCTIONS FOR THE APPLICANT: Give or mail this form directly to your supervisor(s) after you have filled in the bottom portion of this page. If your present supervisor has been supervising you for less than six (6) months, make a copy of this form and provide it to your immediate and past supervisors.

CONFIDENTIAL

Dear Supervisor:

The individual listed below is applying to the Certification Board for Alcohol & Drug Professionals (CBADP) for certification upgrade as a Chemical Dependency Counselor. The information requested here is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application for upgrade can be processed.

The CBADP believes that your observation will provide a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation, plus those received from the professional references and the data furnished by the applicant, will be used in determining eligibility for certification upgrade. The process can only be as good as you and the others make it, by careful and truthful reporting.

Please return the completed evaluation DIRECTLY TO:

CBADP
3101 West 41st Street, Suite 205
Sioux Falls, SD 57105

APPLICANT'S NAME: _____ DATE: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S TITLE & CREDENTIALS: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

AGENCY PHONE: _____

CHEMICAL DEPENDENCY COUNSELOR EVALUATION BY SUPERVISOR
(Continued)

APPLICANT'S NAME: _____

The following items represent the skills needed by a Chemical Dependency Counselor. Evaluate the applicant for their abilities in each area. Mark the rating most descriptive of the individual's demonstrated skills. **A rating of 1 or 2 will cause the application to be denied**. Use N/O (not observed) ONLY if you have never observed nor have any knowledge of the applicant's skill in that area. Please use the following rating scale:

1 – POOR (Not Minimally Acceptable) 2 – NEEDS IMPROVEMENT (Not Minimally Acceptable)
3 – ACCEPATBLE 4 – GOOD 5 – EXCELLENT

COUNSELOR SKILL AREAS	Poor	Excellent	N/O
SCREENING: Determining appropriate and timely services for clients with knowledge of his/her problems and their intensity.	1 2	3 4 5	
CLIENT INTAKE: The process of collecting client information for assessment purposes.	1 2	3 4 5	
CLIENT ORIENTATION: Providing clients with general goals, rules, services, rights, etc. of program services.	1 2	3 4 5	
CLIENT ASSESSMENT: Identification and evaluation of information to determine appropriate treatment services.	1 2	3 4 5	
CHEMICAL DEPENDENCY EVALUATION: Knowledge and application of the major theories and stages of addiction and the symptomatology of chemical dependency for assessment of clients.	1 2	3 4 5	
TREATMENT PLANNING: Defining problems and needs, establishing long- and short-term goals and developing a treatment process and the resources to be used.	1 2	3 4 5	
COUNSELING SKILLS: (Individual, Group, Family) The utilization of special skills to assist in assessing client's problems and facilitating appropriate changes.	1 2	3 4 5	
CASE MANAGEMENT: The coordination of services, agencies, resources or people within a planned framework of action for the achievement of established goals.	1 2	3 4 5	
CRISIS INTERVENTION: Assessing, defining and responding to the needs during acute, emotional, and/or physical distress.	1 2	3 4 5	
CLIENT EDUCATION: Provision of information concerning alcohol and other drug abuse implications, available services, and resources.	1 2	3 4 5	
REFERRAL: Identifying and limiting of appropriate services, familiarization of community and state resources available with demonstration of the referral process, including confidentiality requirements.	1 2	3 4 5	
REPORT AND RECORD KEEPING: Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries, and other client-related data.	1 2	3 4 5	
CONSULTATION: Relating with agency staff and other professionals to assure comprehensive, quality care for clients.	1 2	3 4 5	
PROFESSIONAL & ETHICAL RESPONSIBLITIES: A counselor's ability to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.	1 2	3 4 5	

CHEMICAL DEPENDENCY COUNSELOR EVALUATION BY SUPERVISOR
(Continued)

Are you involved in the administration/management of the program where you are employed?
_____ No
_____ Yes, limited to clinical aspects (i.e., supervision of counselors).
_____ Yes, limited to administrative responsibilities.
_____ Yes, both _____% clinical and _____ % administrative.

How long have you supervised this applicant? _____

For what period of time, while under your supervision, was chemical dependency counseling the major part of this applicant's responsibilities?

From: _____ To: _____

Describe those activities: _____

_____

Comments and/or additional information you feel may be pertinent: _____

_____

I hereby certify that I have been in a position to observe and have first-hand knowledge of the applicant's work at: _____
(Name of work setting)

_____ I recommend this applicant for certification upgrade as a CD counselor.

_____ I have some reservations in recommending this applicant for a certification upgrade.

_____ I do not recommend this applicant be granted the certification upgrade.
(Any rating of 1 or 2 on the 'Counselor Skill Areas' from the pervious page, requires a "do not recommend".)

I hereby certify that all of the above information is, to the best of my knowledge, true.

_____ _____
Signature of Supervisor Date

Professional Recommendation Form

Provide this form to a professional and/or academic colleague who is acquainted with your chemical dependency counseling experience. Provide a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP Administrative Office.

NOTE: ANY INDIVIDUAL WHO HAS COMPLETED THE 'EVALUATION BY SUPERVISOR' FORM FOR THIS APPLICANT MAY NOT SUBMIT A 'PROFESSIONAL RECOMMENDATION' FORM.

PART I - TO BE COMPLETED BY THE APPLICANT

Complete the information below. Give this form to a professional who is acquainted with your work performance and abilities. Be sure to provide the individual with a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP.

Name of Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this recommendation will be used in determining my eligibility for certification upgrade and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

_____ _____

Applicant's signature Date

PART II - TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE

The person listed above has applied for certification upgrade as an Alcohol and Drug Counselor. The signature above authorizes you to complete this form. Your assessment will assist the CBADP in determining the applicant's appropriateness for this certification upgrade. A fair and candid report is essential. Therefore, we ask for careful ratings and comments about character and ability. All information submitted will be viewed as confidential and will not be available to the applicant.

YOUR NAME: _____

POSITON/TITLE: _____

BUSINESS ADDRESS: _____

_____

_____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use "Don't Know" ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILL AREAS	**Poor-Excellent**	**Don't Know**
Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person's professional practice in alcohol and drug abuse counseling.

_____ _____

Signature Date

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DAYTIME TELEPHONE #: _____

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IN WHAT CAPACITY: _____

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POSITON/TITLE: _____

BUSINESS ADDRESS: _____

_____

_____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

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_____ _____

Signature Date